DDD SERVICE COORDINATOR SUPERVISOR
INDIVIDUAL PROGRAM PLAN REVIEW

NAME: _____ DATE OF SEMI-ANNUAL or INTAKE IPP: _____

SC: _____ DATE OF ANNUAL IPP/IFSP: _____

WAIVER: ☐ DDAD ☐ DDAC ☐ DDCSA ☐ CDD SERVICE DISTRICT: _____

Reviews are based on IPP/IFSP documentation. ******* Performance measure for CMS

1. PLAN

A. At a minimum the IPP/IFSP is developed annually and reviewed semi annually. *** ☐YES ☐NO

B. Individual or legal guardian participated in making a choice of waiver providers. *** ☐ YES ☐ NO

2. ASSESSEMENT PLANNING

Required assessments document: strengths ☐YES ☐NO

needs ☐YES ☐NO

preferences ☐YES ☐NO

3. BEHAVIOR MODIFYING MEDICATION

A. If any medication to manage behavior is in place, the name of the medication, dosage, for the medication and specific behavior to be affected by the medication is documented. ☐YES ☐NO ☐NA

B. The IPP/IFSP has documentation of whether the drug is reviewed on an ongoing basis by a physician. ☐YES ☐NO ☐NA

C. If medication to manage behavior is prescribed, there is a documented behavior supports plan and safety plan. ☐YES ☐NO ☐NA

4. RESTRICTIONS

A. Restrictions have a documented rationale. ☐YES ☐NO ☐NA

B. Restrictions have documentation that due process procedures were followed. ☐YES ☐NO ☐NA

C. A plan to reinstate the right is documented, including methods and time frames. ☐YES ☐NO ☐NA

D. Restrictions of rights have written consent from the individual or their legal guardian, as appropriate. ☐YES ☐NO ☐NA

5. REVIEW OF ASSESSMENT & HABILITATION

A. Required medical assessment has been submitted*** ☐ NA ☐YES ☐NO

B. Discussion of assessments is documented. ☐YES ☐NO

C. Did assessments evaluate requested domains? ☐YES ☐NO

D. Plan for the Future is addressed by strategies and outcomes. ☐YES ☐NO

E. Assessed needs are addressed. ☐YES ☐NO

F. There is appropriate habilitation for each applicable service. ☐ NA ☐YES ☐NO

G. The IPP/IFSP was revised due to a change(s) in a person's needs. *** ☐ YES ☐ NO

6. SERVICE NEEDS

A. Medical services are specified and documented on the IPP/IFSP. *** ☐YES ☐NO

B. The frequency and person responsible for each identified service need is documented. ☐YES ☐NO

7. IDENTIFYING INFORMATION

A. The documented authorized units match the state's electronic authorization and billing system. *** ☐YES ☐NO

B. Documented authorized service codes match the state's electronic authorization and billing system. *** ☐YES ☐NO

8. REQUIRED TEAM MEMBERS

A. Signature sheet documents attendance for all required team members. ☐YES ☐NO

B. If the individual did not attend IPP/IFSP, the name of the person responsible for reviewing the contents of the IPP with the individual and by when is documented. ☐YES ☐NO ☐NA

C. If individual did not attend IPP/IFSP documents plan for them to attend future meetings. ☐YES ☐NO ☐NA

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Based on presented information:

☐ **This IPP/IFSP <u>DOES NOT</u> meet the minimum DDD standards. *** (**Check this box if any there were any "no's marked.)

FOLLOW UP ACTION REQUIRED BY DATE: _____ RECEIVED BY DATE: _____
COMMENTS:

☐ **This IPP/IFSP has been determined to meet the minimum Division standards. *****
COMMENTS:

SC Supervisor: _____ Date: